PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for investigation of complaint IN00084888.

Complaint IN00084888 substantiated, federal/state deficiencies related to the allegations are cited at F- 282 and F-323.

Survey dates: February 10 and 14, 2011

Facility number: 000061
Provider number: 155136
AIM number: 100288620

Surveyor: Mary Anne Cilella, RN

Census bed type:
SNF/NF: 148
Total: 148

Census payor type:
Medicare: 16
Medicaid: 114
Other: 18
Total: 148

Sample: 5

These federal deficiencies also reflect state findings in accordance with 410 IAC 16.2.

Quality review completed 2/15/11 by Jennie Bartelt, RN.

F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ED	March 3, 2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited an approved plan of correction is requisite to continued program participation

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to follow physician's orders and the plan of care related to the placement of a personal alarm to alert the staff for 1 of 3 residents who had fallen in the sample of 5. Resident: E Findings include: Interview on 2/14/11 at 9:30 a.m., with the Assistant Director of Nursing (ADON) indicated Resident E had fallen over the weekend and had been sent to the hospital for evaluation. Observation on 2/14/11 at 10:00 a.m., indicated Resident E was seated in a wheelchair across from the nurses' station. The left side of the resident's forehead was bandaged, a dark discoloration was noted under her left eye, and steri- strips were noted behind her left ear. Her left wrist was also covered with a bandage. A chair alarm was in place. Review of the clinical record of Resident E on 2/14/11 at 10:45 a.m., indicated the diagnoses included, but were not limited to depressive disorder, lack of coordination, anorexia and abnormal involuntary movements. The resident had orders signed by the physician with an original date of 6/18/10, for a personal alarm to bed with safety clip and check every shift and a personal alarm to wheelchair, activate every shift.	F 282	F 282 Step One: Applied the personal alarm for Resident E per the plan of care. The CNA assigned to the resident's care was re-educated regarding alarm application. Step Two: All residents with current alarm utilization were visually inspected to ensure appropriate placement of alarms. No deficiencies were noted. Step Three: All Nursing Staff were re-educated regarding alarm utilization and appropriate placement per plan of care. DNS and/or designee will conduct visual observations of alarm placement on 5 random residents daily and report any trends to the QA&A Committee for 180 days. Random audits will occur across all 5 shifts and days of week.	3/16/2011 3/10/11 per admin

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2	F 282		

The quarterly minimum data set (MDS) assessment, dated 11/18/10, indicated the resident required assistance in all areas of daily living. She was coded as not being steady in moving from a seated to standing position, walking, turning around and moving on and off the toilet.

The fall risk assessment dated 12/19/10, indicated the score was 10. A total score of 10 or above deemed the resident at risk for falls.

The plan of care dated 6/10/10, identified the resident to be at risk for falls related to decreased mobility. The approaches included, but were not limited to: nonskid strips on floor next to bed, personal alarm to bed with safety snap, personal alarm to wheel chair with safety snap and foam mattress with contoured edges.

The CNA Care Sheets dated 2/11/11, for Resident E indicated the resident was to have a personal alarm on the wheelchair and the bed.

Review of the nurses' notes on 2/14/11 at 11:00 a.m., indicated at 3:30 p.m. on 2/12/11, the CNA reported to the nursing staff that the resident was found on the floor next to the bed. The resident was noted to have left upper forehead laceration 2 cm. (centimeter) by 2.5 cm, left forehead above the eyebrow laceration 1 cm. by .3 cm, left lateral side of head, 3.4 cm. by .8 cm., left lateral head laceration 3.5 cm. by 3.2 cm, skin tear to left lateral leg below knee 3.6 cm by 2.7 cm. and a skin tear to the left shoulder blade 4 cm. by 2.5 cm. The nursing staff applied steri strips and sent the resident to the hospital. She returned to the facility with the steri strips in place and area care

Step Four:
The QA&A Committee will monitor for any trends monthly for 180 days and will determine the need for any further and/or ongoing monitoring.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 orders. Interview on 2/14/11 at 2:30 p.m., with the ADON indicated the CNA responsible for the resident's care on 2/12/11 was off the unit when the resident was found on the floor. She further indicated the CNA had told her that she had not attached the personal alarm when she put the resident to bed that afternoon. This federal tag relates to complaint number IN00084888. 3.1-35(g)(2)	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement previously identified interventions to prevent falls for a resident who had fallen out of bed, sustained multiple lacerations to the head and shoulder and was sent to the hospital for evaluation. This deficient practice affected 1 of 3 residents who had fallen in the sample of 5. Resident: E	F 323	F 323: Step One: Applied the personal alarm for Resident E per the plan of care. The CNA assigned to the resident's care was re-educated regarding alarm application. Step Two: All residents with current alarm utilization were visually inspected to ensure appropriate placement of alarms. No deficiencies were noted.	3/16/2011

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A BUILDING _____ B WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4	F 323		

Findings include:

Interview on 2/14/11 at 9:30 a.m., with the Assistant Director of Nursing (ADON) indicated Resident E had fallen over the weekend and had been sent to the hospital for evaluation.

Observation on 2/14/11 at 10:00 a.m., indicated Resident E was seated in a wheelchair across from the nurses' station. The left side of the resident's forehead was bandaged, a dark discoloration was noted under her left eye, and steri- strips were noted behind her left ear. Her left wrist was also covered with a bandage. A chair alarm was in place.

Review of the clinical record of Resident E on 2/14/11 at 10:45 a.m., indicated the diagnoses included, but were not limited to depressive disorder, lack of coordination, anorexia and abnormal involuntary movements. The resident had orders signed by the physician with an original date of 6/18/10, for a personal alarm to bed with safety clip and check every shift and a personal alarm to wheelchair, activate every shift.

The quarterly minimum data set (MDS) assessment, dated 11/18/10, indicated the resident required assistance in all areas of daily living. She was coded as not being steady in moving from a seated to standing position, walking, turning around and moving on and off the toilet.

The fall risk assessment dated 12/19/10, indicated the score was 10. A total score of 10 or above deemed the resident at risk for falls.

The plan of care dated 6/10/10, identified the

Step Three:
All Nursing Staff were re-educated regarding alarm utilization and appropriate placement per plan of care. DNS and/or designee will conduct visual observations of alarm placement on 5 random residents daily and report any trends to the QA&A Committee for 180 days.

Step Four:
The QA&A Committee will monitor for any trends monthly for 180 days and will determine the need for any further and/or ongoing monitoring.

Random audits will occur across all shifts and days of week. DW 2/10/11 per admin.

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

resident to be at risk for falls related to decreased mobility. The approaches included, but were not limited to: nonskid strips on floor next to bed, personal alarm to bed with safety snap, personal alarm to wheel chair with safety snap and foam mattress with contoured edges.

The CNA Care Sheets dated 2/11/11, for Resident E indicated the resident was to have a personal alarm on the wheelchair and the bed.

Review of the nurses' notes on 2/14/11 at 11:00 a.m., indicated at 3:30 p.m. on 2/12/11, the CNA reported to the nursing staff that the resident was found on the floor next to the bed. The resident was noted to have left upper forehead laceration 2 cm. (centimeter) by 2.5 cm, left forehead above the eyebrow laceration 1 cm. by .3 cm, left lateral side of head, 3.4 cm. by .8 cm., left lateral head laceration 3.5 cm. by 3.2 cm, skin tear to left lateral leg below knee 3.6 cm. by 2.7 cm. and a skin tear to the left shoulder blade 4 cm. by 2.5 cm. The nursing staff applied steri strips and sent the resident to the hospital. She returned to the facility with the steri strips in place and area care orders.

Interview on 2/14/11 at 2:30 p.m., with the ADON indicated the CNA responsible for the resident's care on 2/12/11 was off the unit when the resident was found on the floor. She further indicated the CNA had told her that she had not attached the personal alarm when she put the resident to bed that afternoon.

This federal tag relates to complaint number IN00084888.

3.1-45(a)(2)

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. BUILDING _____ B. WING _____	C 02/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	1900 ANDREW AVENUE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE